VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 22, 2019

Mr. Bruce Francis, Manager
Home Sweet Home
99 Atkinson Street
Bellows Falls, VT 05101

Dear Mr. Francis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 31, 2019.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0661	A. BUILDING _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME SWEET HOME	99 ATKINSON STREET BELLOWS FALLS, VT 05101

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R100	Initial Comments: An unannounced on-site re-licensure survey was conducted, in conjunction with four anonymous complaints, by the Division of Licensing and Protection on 7/31/19. There were regulatory findings.	R100	Please see attached plans of correction.	
R104 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the	R104		

R104 - R303 POC accepted BBartell RN/PMC 8/22/19

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R104	Continued From page 1 ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include the daily, weekly, or monthly rate to be charged for one of six residents reviewed, Resident #4. Findings include: Resident #4 was admitted to the facility 4/15/19 and entered into a signed admission agreement with the facility. There is no evidence that the facility included the daily, weekly, or monthly rate to be charged. In addition Resident #4 is an ACCS participant (Assistive Community Care Services) and there is no evidence that the amount of personal needs allowance (PNA) was listed or discussed. The manager confirmed, at 1:05 PM, that the amounts had not been included and was not sure why the rate was not included, but stated that they were waiting to find out what the PNA would be and didn't think anything needed to be filled in until the amount was decided upon.	R104		
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or	R114		

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R114	Continued From page 2 transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so. iii. Include a statement in the written notice that the resident may remain in the room or home during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide 1 of 2 applicable residents and/or their representative of a full thirty (30) days notice of a facility initiated discharge. (Resident #4). The findings include the following: On 7/11/19 The licensing agency received a	R114		

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R114	Continued From page 3 facsimile (fax) reporting an involuntary discharge notice that was provided to Resident #4 and his/her representative dated 7/11/19, with a plan to discharge the resident on 7/31/19. The notice provides the resident with only a 20 day notice of discharge. The resident remains in the facility currently. Confirmation was also made by the manager on July 31, 2019 during the interview, that the facility determined that the resident presented with a risk to others and required police intervention. Therefore, the facility assumed this to be an emergency discharge.	R114		
R116 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.b Emergency Discharge or Transfer of Residents (1) An emergency discharge or transfer may be made with less than thirty (30) days notice under the following circumstances: i. The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other residents; or ii. A natural disaster or emergency necessitates the evacuation of residents from the home; or iii. The resident presents an immediate threat to the health or safety of self or others. In that case, the licensee shall request permission from the licensing agency to discharge or transfer the	R116		

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R116	Continued From page 4	R116		

resident immediately. Permission from the licensing agency is not necessary when the immediate threat requires intervention of the police, mental health crisis personnel, or emergency medical services personnel who render the professional judgement that discharge or transfer must occur immediately. In such cases, the licensing agency shall be notified on the next business day; or

iv. When ordered or permitted by a court.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that the Licensing Agency was notified on the next business day after an emergency discharge for 1 of 2 applicable residents, (Resident #1). The findings include the following:

1.) In review of the medical record for Resident #1, it identifies numerous occasions since admission (05/01/19), of incidents of verbal abuse towards other residents (Residents #3, #4 and #6) and staff, occasions of unwanted physical touching (Resident #6) on his/her breast, kissing staff and invading their space, aggressive behavior that demonstrated as banging doors, throwing various materials at staff and leaving the facility without notice for periods as long as 4 hours in duration. The resident was returned to the facility by the police on approximately 8 different times during the months of June through July 16, 2019. Resident #1 was also returned to the facility by unknown individuals on two separate occasions, after being lost in town, s/he was found walking down the street during rainstorms and found to be soaking wet. Documentation also identifies, that many times Resident #1 would go to another Residential Care

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R116	Continued From page 5 Home that he/she had previously lived in. On 7/17/19 The licensing agency received a complaint dated reporting an involuntary discharge notice. This notice was provided to Resident #1 and his/her representative dated 7/16/19. Confirmation was made by the manager during interview on 7/31/19, that they were unaware of the need to report an emergency discharge within the next business day. Confirmation was also made at the time of interview by the manager, that the facility determined that the resident presented with a risk to others, required police intervention, an emergency discharge notice was appropriate and did not require a 30 day notice. The resident was not returned.to the facility at their request.	R116		
R134 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an assessment within 14 days of admission for five of six residents in the sample, Resident #1, #2, 4, 5 and 6. Findings include:	R134		

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R134	Continued From page 6 1.) In review of the medical records for Resident #2, 4, 5 and 6, there was no evidence that the 14 day admission assessment was completed. During an interview with the manager, s/he stated that they did not think that assessments needed to be completed on residents that had Enhanced Residential Care (ERC) or Assistive Community Care Services (ACCS). The Registered Nurse confirmed at 1:10 PM that the assessments had not been completed. 2.) Per medical record review for Resident #1, who was admitted to the facility on 05/01/19. The resident assessment was conducted on 05/22/19 and was signed by the Registered Nurse (RN) as completed on 05/23/19. Confirmation was made by the RN on 07/31/19 at 9:55 AM that the assessment was 9 days overdue.	R134	Note: Resident #5 RA was completed and signed 7/16/19. Her admit date was 7/15/19.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the Registered Nurse	R145		

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R145	Continued From page 7 oversaw the development of written plans of care for five residents, Resident #1, 2, 3, 4 and 5. Findings include: 1.) The Registered Nurse (RN) stated, on 7/31/19 at 2:15 PM, that Resident #5 self-administers medications and s/he had been assessed for competency. There is no evidence in the medical record for Resident #5 that a care plan was developed regarding the ability to self-administer. The RN confirmed at 2:15 PM that there had been no care plan regarding self-administration of medications. 2.) Per review of the care plans for Residents #1, #2, #3 and #4, do not identify that the RN developed and/or approved the care plans as written related to all problems/goals and initiatives to manage such problems. The RN confirmed on 7/31/19 throughout the day long interview that s/he is unable to evidence that s/he did develop and/or approve the care plans for Residents #1, #2, #3 and #4.	R145		
R165 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's	R165		

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R165	Continued From page 8	R165		

condition, relevant medications, and potential side effects;
ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;
iii. Assessing the resident's condition and the need for any changes in medications; and
Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to insure that the Registered Nurse (RN) assessed one resident in the applicable sample, Resident #6, for which unlicensed staff assist with diabetic medication. Findings include:

Resident #6 has diagnoses that includes Diabetes which requires administration of insulin and blood sugar testing. There is no evidence from the review of the nurse progress notes that the RN monitors and evaluates his/her condition. Resident #6 is provided an insulin Flexpen, in the presence of non licensed staff, that s/he must dial to the correct dose depending on the results of the blood sugar test. The RN stated that Resident #6 has had fluctuations in his/her blood sugars and it will often affect his/her Dissociative Identity Disorder (DID) and requires need for medication adjustments for the DID. The RN confirmed, on 7/31/19 at 2:00 PM, that s/he does monitor and evaluate the diabetic condition, but does not document the stability of the resident's diabetic status.

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R173	Continued From page 9	R173		
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES	R173		

5.10 Medication Management

5.10.h.

(1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys

This REQUIREMENT is not met as evidenced by:
Based on interview and staff interview, the staff failed to insure that medications that the home manages must be stored in locked compartments under proper temperature controls. Findings include f:

1.) During the initial tour of the facility there was a Ventolin Inhaler on the bedside stand in the room that is occupied by Resident #4. In review with the Registered Nurse (RN) on 7/31/19 at 2:00 PM, s/he confirmed that Resident #4 had an order for Ventolin and was unaware that it was in his/her room. The RN stated that it should not be in his/her room, and is unsure of when it was last used. but the inhaler should be kept with the rest of the medications and not in the resident's room.

2.) Resident #5 was assessed by the Registered Nurse to be competent to self-administer medications. During an interview with Resident #5, s/he stated that s/he takes one or two Baby Aspirin per day, depending on the "aches and pains of the day". It was observed that the bottle

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R173	Continued From page 10 of Baby Aspirin was sitting in a shallow container at the chair side in his/her room. It was also observed during the survey that the when Resident #5 left their room, the Baby Aspirin had not been placed in a secure storage area. Interview with the resident at 2:10 PM, s/he stated that s/he has no knowledge of needing to secure her Aspirin and it is always kept in the container it is in. The Registered Nurse confirmed at 2:15 PM that the resident has Baby Aspirin in their room and that it isn't in a secure storage space	R173		
R175 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (3) Residents who are capable of self-administration may choose to store their own medications provided that the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to insure secure storage space to prevent the unauthorized access to the self-administered medications for one resident, Resident #5. Findings include: Resident #5 was assessed by the Registered Nurse to be competent to self-administer medications. During an interview with Resident	R175		

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R175	Continued From page 11 #5, s/he stated that s/he takes one or two Baby Aspirin per day, depending on the "aches and pains of the day". It was observed that the bottle of Baby Aspirin was sitting in a shallow container at the chair side in his/her room. It was also observed during the survey that the when Resident #5 left their room, the Baby Aspirin had not been placed in a secure storage area. Interview with the resident at 2:10 PM, s/he stated that s/he has no knowledge of needing to secure her Aspirin and it is always kept in the container it is in. The Registered Nurse confirmed at 2:15 PM that the resident has Baby Aspirin in their room and that it isn't in a secure storage space.	R175		
R188 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by:	R188		

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R188	Continued From page 12 Based on staff interview and record review, the facility failed to insure that six of six residents, Resident #1, 2, 3, 4, 5 and 6, medical records contained all the required information, which includes a recent photograph, physician's name, address and phone number, as well as lack of information with instructions in case of resident's death. Findings include: 1.) There was no evidence, during record review of the six residents in the sample, Resident #1, 2, 3, 4, 5 and 6, that a recent photograph had been obtained and there is no documentation that the resident refused to have a photograph taken. Confirmation was made by the house manager and the Registered Nurse, at 12:05 PM, that the facility had not obtained recent photographs of the residents. 2.) Resident #4 has no evidence of physician address and telephone numbers and Resident #4 and 6 do not have evidence of instructions in the case of death. The manager confirmed, at 2:00 PM on 7/31/19, that the information is not in the record.	R188		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain and keep on file the results of the criminal record and adult registry for	R190		

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R190	Continued From page 13 five employees in the sample of five. Findings include: A review of the employee background checks, for five employees, was conducted with the house manager on 7/31/19 at 1:30 PM and there was no evidence that adult registry checks were conducted. The manager stated that the facility employs a national security check company that does criminal back ground checks for every state that the potential employee has lived by reviewing their social security number against the fifty states data base. The manager further stated at this time that there is no evidence that adult abuse registry checks are included in the reports and there have been no Vermont State specific criminal background checks conducted.	R190		
R191 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file.	R191		

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	0661	A. BUILDING: _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME SWEET HOME	99 ATKINSON STREET BELLOWS FALLS, VT 05101

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R191	Continued From page 14	R191		

5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained.

5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours.

5.12.c. (5) A written report of any reports or incidents of abuse, neglect or exploitation reported to the licensing agency.

5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide the licensing agency with a written report of incidents of resident-to-resident abuse, for 4 of 6 residents in the sample (Residents #1, #3, #4 and #6). The findings include the following:

1.) Per medical record review for Resident #1, progress notes identifies numerous occasions since admission (05/01/19), of incidents of verbal abuse towards other residents (Residents #3, #4

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R191	Continued From page 15	R191		

and #6), occasions of unwanted physically touching (Resident #6) on his/her breast, invading others space, aggressive behavior that demonstrates as banging doors, throwing various materials at staff and leaving the facility without notice for periods as long as 4 hours in duration.

Confirmation was made on 07/31/19 with both the Registered Nurse (RN) and the Manager, that the facility staff have attempted to notify Licensing and Protection of many of the above incidents. The licensing agency has not received any written reports related to resident-to-resident incidents of verbal/physical and/or sexual abuse involving Residents #1, #3, #4 and #6.

2.) Per incident report review dated 7/10/19 at approximately 3:15 PM, documentation identifies that Resident #4, physically assaulted Resident #3 on the left side of his/her face to include threatening abusive language with yelling while on the upper level deck. No physical injuries resulted to either resident. The Police were notified.

The licensing agency confirms that they have not received and written reports related to the resident-to-resident physical and verbal altercation that took place on 7/10/19 between Resident #3 and #4. Confirmation was made by the manager during review on 7/31/19 that the facility was unaware of the requirement to report resident-to-resident altercations.

See also R224.

R208 SS=E V. RESIDENT CARE AND HOME SERVICES R208

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R208	Continued From page 16 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to report to the licensing agency incidents of resident-to-resident physical and/or sexual abuse that resulted in physician intervention and/or a pattern of abusive behavior, for 4 of 6 residents in the sample (Resident #1, #3, #4 and #6). The findings include the following: 1.) Per medical record review for Resident #1, identifies numerous occasions since admission (05/01/19), of incidents of verbal abuse towards other residents (Residents #3, #4 and #6), occasions of unwanted physical touching (Resident #6) on his/her breast, invading others space, aggressive behavior that demonstrates as banging doors, throwing various materials and leaving the facility without notice for periods as long as 4 hours in duration. On 07/16/19 at approximately 11:15 AM, while in the dining room, Resident #1 picked up a hammer and nails from the floor. Staff intervened, were able to retrieve the hammer and nails without incident.	R208		

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R208	Continued From page 17	R208		

Confirmation was made by the Registered Nurse (RN) and the Manager on 7/31/19, that they were unaware of the requirement to report to the licensing agency incidents of resident-to-resident abuse. The licensing agency has not received any reports related to resident to resident incidents for Residents #1, #3, #4 and #6.

2.) Per incident report review dated 7/10/19 at approximately 3:15 PM, documentation identifies that Resident #4, physically assaulted Resident #3 on the left side of his/her face to include threatening abusive language with yelling while on the upper level deck. No physical injuries resulted to either resident. The Police were notified and responded to the facility.

Confirmation was made by the Registered Nurse (RN) and the Manager on 7/31/19, that they were unaware of the requirement to report to the licensing agency incidents of resident-to-resident abuse. The licensing agency has no received any verbal or written reports related to resident to resident incidents for Residents #1, #3, #4 and #6.

See also R224.

R224 SS=E VI. RESIDENTS' RIGHTS — R224

6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.

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R224	Continued From page 18	R224		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that 4 of 6 sampled residents were free from physical and sexual abuse, (Residents #1, #3, #4 and #6). The findings include the following:

1.) Per medical record review for Resident #1, identifies with numerous occasions since admission (05/01/19), of incidents of verbal abuse towards other residents (Residents #3, #4 and #6) and staff, occasions of unwanted physical touching (Resident #6) on his/her breast, kissing staff and invading others space, aggressive behavior that demonstrated as banging doors, throwing various materials and leaving the facility without notice for periods as long as 4 hours in duration.

On 07/07/19 at approximately 2 PM, Resident #1 was making threatening sexual remarks intimidating residents and staff. Police/EMT's called and Resident #1 was transported to the Emergency Room (ER) for evaluation.

On 07/12/19 at approximately 2 PM, Resident #1 had a physical altercation with Resident #6 that required staff to intervene. Police called and responded to the facility.

On 07/13/19 at approximately 10:30 AM, Resident #1 was pacing in the dining room. Resident #6 passed
Resident #1 and reached out and touched his/her breast. Resident #6 responded by slapping Resident #1 stating ["Don't touch me."].

On 07/14/19 at approximately 4:15 PM, staff heard yelling and witnessed as Resident #4 was

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R224	Continued From page 19	R224		

yelling at Resident #1 while pointing a finger saying ["Leave her alone."]. Police were notified.

On 07/15/19 at approximately 9 PM, Resident #1 touched Resident #6 once again.

On 07/16/19 at approximately 10:45 AM, Resident #6 accused Resident #1 of assaulting him/her on the left shoulder with his/her hand.

On 07/16/19 at approximately 11:15 AM, while in the dining room, Resident #1 picked up a hammer and nails from the floor. Staff intervened, were able to retrieve the hammer and nails without incident.

2.) Per incident report review dated 7/10/19 at approximately 3:15 PM, documentation identifies that Resident #4, physically assaulted Resident #3 on the left side of his/her face to include threatening abusive language with yelling while on the upper level deck. No physical injuries resulted to either resident. The Police were notified and responded to the facility.

Care plan review for Resident #4 dated 6/11/19, identifies altered behaviors and altered thought process: touching others, towering over others, invading others space to intimidate with initiatives of reminding the resident not to touch, provide distraction, to monitor behaviors while in house, remind resident of appropriateness, monitor for safety and remind him/her of the house rules Also has identified violent behavior dated 7/12/19 with initiatives of setting limits of 3 feet of space between resident and others, staff to be calm and not to touch the resident and to promote trust. Call 911 if needed.

Care plan review for Resident #4 dated 7/9/19,

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R224	Continued From page 20 identifies risk for violent behavior with interventions to observe, deescalate, remove objects that could cause harm, encourage time out and medication administration as needed. Also, has an identified agitation problem related to lack of funds or cigarettes. Initiatives include rationing of cigarettes, provide guidance with expenses, discouraging sharing of cigarettes and to monitor. Per discussion with the facility manager and the RN on 7/31/19 during the review, confirmation is made that it is difficult to determine when resident-to-resident altercations will occur. They also confirm that the above altercations did happen as documented in each medical record and/or report.	R224		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that perishable food were labeled, dated and held at proper temperature. Findings include: During the initial tour of the kitchen on 7/31/19 at 9:25 AM, it was observed that in the resident's freezer, there were opened bags of hash browns,	R247		

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R247	Continued From page 21 Brown and Serve sausages and french fries that were not labeled with a date when they were opened. The kitchen refrigerator had clear plastic bags of what appeared to be broccoli, Kielbasa, and shredded cheese. These were not labeled to the content and no date as to when the food was placed in the bags. The cupboards contained open boxes and containers of food items, peanut butter, crackers, taco shells, cereals, baking chips, cookies and sugar and none were labeled with a date they were opened. Review with the manager at the time of discovery gave confirmation that these items were not labeled properly. There was no evidence, during further review of the kitchen, that temperature logs of food is being recorded to insure that storage is per regulations and the manager stated at this time that s/he thought that the temperatures were being recorded, but there is no evidence of the logs.	R247		
R259 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to insure that cleaning products that are stored in the food storage area are in a separate, locked compartment. Findings include:	R259		

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R259	Continued From page 22	R259		

During the initial kitchen tour on 7/31/19 at 9:25 AM, under the kitchen sink there was a box of individual coffee K-cups, Humidi-clean descaler, shower cleaner, glass cleaner and paint cleaner. In the other base kitchen cupboard, bleach, Pine Sol cleaner and other types of cleaners were stored. The caregiver confirmed these items were stored in the kitchen cupboards at the time of discovery. The house manager was notified and stated that s/he was unaware that the cleaning supplies and chemicals needed to be secured but did confirm that they were not stored as required.

R266 SS=E — IX. PHYSICAL PLANT — R266

9.1 Environment

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to provide a safe, functional, sanitary, homelike and comfortable environment. Findings include:

While doing the facility tour, the door leading to the third floor was unlocked at the top of the stairs, which is not occupied by residents, and per the house manager it is not to be accessed by the residents. On the third floor, there are tools and paints that are being stored. On the second floor, Room #4 was not locked and can also be

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R266	Continued From page 23 accessed by residents. In Room #4, there was cans of open paint, drywall and a drill. The manager confirmed at 10:00 AM, that the third floor door should be locked and there were residents that were capable of entering the third floor and accessing the tools and paints that are stored there, and further stated that Room #4 should not have the paint, drywall and drill stored there, but because they are, the door should be locked.	R266		
R303 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to insure that each floor of the facility have an operable telephone. Findings include: During tour of the facility, there was no evidence that there was a telephone on the second floor, which has resident occupancy. An interview with one of the residents that resides on the floor revealed that there is no phone on the floor and s/he does not have their own phone. The manager confirmed tat 11:00 AM that there is no phone on the second floor.	R303		

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	**Our Action to correct**	**Measure or change made to prevent reoccurrence**	**How the corrective ACTION will be monitored**	**Dates Corrective action will be completed**
R104 Failure to include the rate charged admission agreement. PNA was not included on admission agreement	All admission agreements modified with rate charged and PNA	Admission checklist generated to assure inclusion of completion of page 6,7 and 11 on the Admission agreement	Weekly audit on any new patient charts until checklist is complete	8/15/19
R114 Failure to provide a full 30 day notice of discharge for #4	Will provide full 30 day notice of discharge to all residents planned to be discharged. Resident #4 continues to reside in house at this writing.	Education provided to management and RN related to Reg 5.3.a	Weekly audit for any planned discharges	8/14/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	**Our Action to correct**	**Measure or change made to prevent reoccurrence**	**How the corrective ACTION will be monitored**	**Dates Corrective action will be completed**
R116 Failure to notify licensing agency on next business day of emergency discharge of resident #1	Will notify licensing agency on the next business day of any emergency discharge	Education provided to Management and RN related to reg 5.3.b	Weekly audit for any imminent/potential need for discharge	8/14/19
R134 Failure to complete admission assessment on all residents within 14 days of admission	Will complete admission assessment on all new residents within 14 days of admission	Education provided to management and RN related to reg 5.7.a Admission checklist generated to include RA within 14 days on ALL residents	Weekly audit on any new patient charts until checklist is complete	8/15/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	**Our Action to correct**	**Measure or change made to prevent reoccurrence**	**How the corrective ACTION will be monitored**	**Dates Corrective action will be completed**
R145 Failure to generate care plans for self administration of medication Failure to identify the RN had developed or approved Care plans	Care plans generated for self administration of medication All care plans are now initialed by RN	Education provided to RN related to 5.9.c	Weekly audit for care plans of any resident with self admin medications Weekly audit for RN initials on all care plans	8/15/19 8/15/19
R165 Failure to insure the RN assessed unlicensed staff's ability to assist with diabetic medication	Resident #6 was assessed for unlicensed staff to assist with diabetic medication in weekly progress note. RN will write monthly note addressing resident DM condition, ability to perform finger sticks, and insulin administration with supervision of staff	Education provided to management and RN related to reg 5.10.d	Weekly audit for monthly or more frequent progress note stating DM condition and residents ability to safely continue with staff assisted DM medication administration	8/15/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	**Our Action to correct**	**Measure or change made to prevent reoccurrence**	**How the corrective ACTION will be monitored**	**Dates Corrective action will be completed**
R173 1) Failure to insure medications that the home manages are stored in locked compartment	Removed unlocked medication from bedside and returned to locked med cart	Informed resident #4- no medications at bedside Educated staff on medication storage	Weekly audit of resident room for OTC or RX with their permission	8/20/19
2) Failure to have medications that resident manages in locked storage	All medications are in lock box provided	Lock box provided	Weekly audit for locked storage in room for any resident with self administration	8/20/19
R175 Failure to insure secured self medications space #5	All medications locked in new lock box	Lock box provided	Weekly audit of any resident with self admin medication orders- for locked storage	8/20/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	Our Action to correct	Measure or change made to prevent reoccurrence	How the corrective ACTION will be monitored	Dates Corrective action will be completed
R188 Failure to provide recent photograph of all residents	Photographs acquired and place in resident charts	Added "photo in chart" to admission checklist	Weekly audit of admission checklist on all new admissions until complete	8/14/19
R188 Failure to have complete physician address and telephone numbers	All resident charts have been completed with healthcare provider Name, address and telephone number	Admission checklist includes completion of intake form	Ditto	8/14/19
Did not have evidence of instructions in the event of death	All charts now have completed "in case of death form" with contacts and funeral home	Admission checklist includes "in case of death" form	Ditto	8/19/19
R190 Failure to keep record of Vermont Criminal Record check and Adult registry for employees	Obtain Vermont Criminal Record check and Adult registry for all employees	Generating a "Management To Do" checklist prior to allowing employee to begin work with residents	Daily review of "Management To Do" checklist until complete	ongoing

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	**Our Action to correct**	**Measure or change made to prevent reoccurrence**	**How the corrective ACTION will be monitored**	**Dates Corrective action will be completed**
R191 Failure to report "in writing" to the licensing agency of resident to resident abuse, within 72 hours	Will report any resident to resident abuse verbally/phone within 24 hours with follow up in writing within 72 hours to licensing agency	Education provided to all staff on Resident to Resident abuse and reporting	Weekly audit of progress notes for indication of Resident to Resident abuse and reporting of such	8/13/19
R208 Failure to report to licensing agency resident to resident abuse	Will report any resident to resident abuse verbally/phone within 24 hours with follow up in writing within 72 hours to licensing agency	Education provided to all staff on Resident to Resident abuse and reporting	Weekly audit of progress notes for indication of Resident to Resident abuse and reporting of such	8/3/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	Our Action to correct	Measure or change made to prevent reoccurrence	How the corrective ACTION will be monitored	Dates Corrective action will be completed
R224 Failure to ensure residents are free from physical and sexual abuse	Will insure all residents are free from any abuse	Education is being provided to all staff related to the **SEARCH** method of prevention: Support Evaluate Act Report Careplan Help to avoid abuse And **R-REM** Resident to Resident Elder Mistreatment	Weekly audit for staff education completion	Ongoing
R247 Failure to label perishable food with date	All food have been labeled with date open and contents if not in original container	Education provided to all staff of reg 7.2.b	Weekly audit for compliance	8/5/19
Failure to record refrigerator and freezer temperatures	Temperature logs in place on all refrigerators and freezers		Weekly audit for compliance	8/5/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	**Our Action to correct**	**Measure or change made to prevent reoccurrence**	**How the corrective ACTION will be monitored**	**Dates Corrective action will be completed**
R259 Failure to separate cleaning product form food and providing locked storage for cleaning supplies	All cleaning products have been separated from food and are in locked storage	Education provided to all staff	Weekly audit for compliance	8/5/19
R266 Failed to provide a safe , functional, sanitary, homelike and comfortable environment ... Unlocked 3rd floor and unlocked storage of construction tools and supplies (3rd and 2nd floor)	3rd floor is secured by a lock 2nd floor work room is secured by a lock while not in use	Maintenance personnel notified of regulation 9.1.a, locks installed	Weekly audit for compliance	8/2/19

Plan of Correction Due 8/22/19	Home Sweet Home	99 Atkinson Street	Bellows Falls , Vermont	05101
Deficiency	Our Action to correct	Measure or change made to prevent reoccurrence	How the corrective ACTION will be monitored	Dates Corrective action will be completed
R303 Failure to insure that an operable telephone is available on 2nd floor	Operable telephone installed on 2nd floor with list of emergency telephone numbers posted	Phone installed Management aware of regulation 9.11.d requiring telephone on each resident floor	Weekly audit for compliance	8/3/19